

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/06/2014
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00149488 completed on May 21, 2014.</p> <p>Complaint IN00149488-Corrected</p> <p>Survey date: June 6, 2014</p> <p>Facility number: 002627 Provider number: 002627 AIM number: N/A</p> <p>Survey team: Heather Hite, RN, TC Julie Ferguson, RN</p> <p>Census bed type: Residential: 118 Total: 118</p> <p>Census payor type: Other: 118 Total: 118</p> <p>Residential sample: 2</p> <p>Brentwood at Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00149488.</p> <p>Quality review completed on June 9, 2014, by Janelyn Kulik, RN.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE